PTSD in contemporary Veterans: The impediments to VA care

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The modern Veterans Administration (VA) system, traditionally resourced to meet the needs of aging veterans, is struggling to keep up with current demand for PTSD and other mental health services. Despite new policies designed to streamline and expedite VA mental health services, the bureaucracy of the VA is slow to respond to the dynamic demands of changing warfare (Yano, Simon, Lanto, & Rubenstein, 2007). The warfare experienced by soldiers in the Global War on Terror is very different from previous wars (Hoge, Castro, Messer, McGurk, Cotting, and Koffmann, 2004). Returning service personnel have experienced improved battlefield medicine and advanced body armor leading to fewer deaths, but a greater number of traumatized survivors has resulted (U.S. Government Accountability Office, 2008).

The Impact of the Global War on Terror

The ratio of wounded to killed in action for soldiers in Iraq is seven to one (Fisher, Klarman, & Oboroceanu, 2008). This is compared to casualty ratios of roughly two to one in World War II and three to one in the Korea and Vietnam wars (Fisher, Klarman, & Oboroceanu, 2008). More soldiers are returning from battle bearing wounds reflecting the logistics of a modern battle tactics and improved body armor. Rates of traumatic brain injuries, for example, have increased due to the use of strong, but lightweight Kevlar helmets, which prevents wounds but not the jarring physiological damage a bomb causes to the brain (Okie, 2005).

The sequelae of neoteric warfare has led to an unprecedented overall rise in patient enrollment at the VA, precipitated by a dominance of poly-trauma including traumatic brain injury and posttraumatic stress disorder (Yano et al., 2007). According to the Rand Corporation Research Brief (2008), 18.5 percent of veterans returning from the Global War on Terror currently have PTSD or depression and 19.5 percent report having a traumatic brain injury. A study of 3,863 soldiers who found in the Iraq war, 16.6 percent met screening criteria for PTSD one year following deployment (Hoge, Terhakopian, Castro, Messer, & Engel, 2007). Comparatively, the rate of PTSD in the general population is between two and four percent (Hoge et al., 2004). PTSD, though present in the general population, is much more pervasive in those returning from active combat duty. Hoge et al. (2004) found nine percent of soldiers at risk for mental disorders before deployment, and 11-17 percent at risk following deployment. Due to experiential variations in the theaters of operations, soldiers returning from Iraq had significantly higher rates of mental disorders, falling closer to 17 percent, than soldiers returning from Afghanistan. Of all the mental disorders measured by Hoge et al. (2004) (depression, anxiety, and PTSD), PTSD rates increased the most following deployment. The modern battlefield presents new challenges for the VA as soldiers return home. Despite the mental health policy changes VA had made, there are many barriers, which impede the ingress of veterans to treatment.

Barriers to Care

Soldiers returning from war with PTSD face many obstacles to receiving care. One of the most notable is the reluctance of veterans to seek treatment. Hoge et al. (2004) found that those who were most in need of mental health counseling were the most resistant to receive it. This study of infantry tropes found those with a higher degree of mental health symptoms identified more strongly to the list of barriers to care. Some of the items on the list of barriers include: a mistrust of mental health professionals, difficulty in fitting treatment into the work schedule, social stigma of seeking help, being seen as weak for seeking mental health treatment, and the perception of the ineffectiveness of mental health treatment (Hoge et al., 2004). Only 23 to 40 percent of soldiers in the Hoge et al. (2004) study sought treatment for their mental health issues. A more recent study of returning soldiers also found roughly half of those with mental health needs seek treatment for it (Rand, 2008).

Looking specifically at disability benefit applicants, Sayer and colleagues found only roughly half of all PTSD disability claimants were receiving treatment for it (Sayer, Clothier, Spoont, & Nelson, 2007). Though seeming advantageous for a disability claimant to seek treatment for his or her debilitating PTSD, barriers to care were cited to explain the low number of care seekers. The barriers to treatment from Sayer et al. (2007) echo those from the Hoge (2004) article. Possible barriers offered by Sayer and her colleagues included: fear of stigmatization, difficulty in accessing care, and doubt of the utility of mental health counseling. The Sayer et al. (2007) study found that there were certain demographic groups who were more likely to seek treatment during their claims process. These protective factors included: being

married, being younger, and being on public insurance. They found no relation between problem recognition or the degree of functional impairment to an increase in seeking mental health treatment at the VA. The Rand Corporation Research Brief (2008) study of both VA and Department of Defense mental health provision concurred with the aforementioned barriers to care studies. The Rand Brief also described structural as well as personal, organizational, and cultural factors which limit the access of mental health services to returning soldiers.

VA Systemic Barriers

Over the past century, the VA has evolved into an enormous health care system, the largest in the United States (Ibrahim, 2007). There are not many "out of network" opportunities for VA care. Otherwise uninsured veterans generally have no choice of where they receive services. They must utilize the VA clinic that is within driving distance from their home. Receiving mental health services exclusively from the VA creates many barriers to care for veterans. Frequently veterans experience long wait times for initial appointments. The U.S. Government Accountability Office (2007) reported follow up appointments for PTSD at Veterans Administration programs can by delayed by 90 days. So burdened is the VA with veterans from previous wars, the VA asked their medical facilities to give Iraq and Afghanistan veterans priority appointments (U.S. Government Accountability Office, 2007).
Obtaining care becomes a double albatross for rural veterans who often do not have ready access to VA facilities. The process of attaining benefits, sometimes driving long distances to a center, and then perhaps being put on a waiting list creates many obstacles to receiving care. Adding to this labyrinth are the VA benefit seekers, who are seeking a PTSD assessment and care while concurrently applying for benefits. The VA is forced to serve a dual role of gatekeeper and care giver which can alter the basic therapeutic relationship between the veteran and VA care provider. Compensation-seeking veterans with PTSD may experience a mutual atmosphere of distrust at the VA (Frueh, Grunbaugh, Elhai, & Buckley, 2007; Kato & O'Malley, 2007).

PTSD and VA Disability Benefits

The concept of PTSD being a disability has evoked controversy in the veterans' community. Much of this controversy is tied to the way the VA determines its priority system providing access to health care and cash disability benefits. Veterans claiming a PTSD disability can qualify for a priority one, two, or three access to care (Veterans' Administration, 2008). Qualifying for a PTSD disability not only allows veterans to gain more expeditious medical care, but also provides for disability benefits. The policy of proving PTSD disability to receive access to medical care and benefits creates an environment of presentiment from both the veterans seeking care and providers. The negotiation of the complex VA process and feelings of powerlessness associated with filing a disability claim can lead to veteran mistrust in the VA (Kato & O'Malley, 2007). Undergirding the mistrust by VA staff is the supposition that disability payments incentivize pathology and discourage recovery. According to Frueh and colleagues (2007), many VA clinicians are suspicious of veterans with PTSD complaints because they assume they are trying to access or maintain disability payments. Department of Veterans' Affairs figures demonstrating an increase in PTSD disability payments of 79.5 percent from 1999 to 2004 has brought PTSD disability compensation to the forefront (Frueh et al., 2007). This dramatic increase in PTSD claims is compared to payments for other disabilities which rose only 12.2 percent (Frueh et al., 2007). Frueh and his colleagues point to fraud and misrepresentation by veterans as an explanation of the disproportionate rise in PTSD claims. According to Frueh et al. (2007), the majority of veterans who sought mental health treatment for PTSD concurrently applied for disability benefits. He and his team examined the role of

symptom overreporting during the disability claims process. Kashdan, Elhaj, & Frueh (2007) found that overreporters were more likely to express a greater level of anhedonia than non overreporters. This malingering depression was seen as an advantageous symptom to misrepresent, increasing the perception of an inability to work. The premise of this research is that unqualified people will apply for PTSD related disability because they can receive a sizable salary from the disability claim. Further, if they remain sick, they will continue to get paid.

Contradictory evidence has been presented by other researchers which challenges the accuracy of research on misrepresentation of PTSD. Looking at prior studies on symptom exaggeration, Dohrenwend, Turner, Adams, Karestan, & Randall (2007) found discrepancies were due to differences in PTSD definitions published in subsequent editions of the Diagnostic Statistical Manual. More recent research found claimants' psychiatric status did not improve nor did they drop out of treatment following disability claim determination (Sayer, Spoont, Nelson, Clothier, & Murdoch, 2008). An additional study by the same group found that, although psychiatric symptoms increased during the disability claims process, they reverted to the pre-examination level following claim determination (Spoont, Sayer, Nelson, Clothier, Murdoch, & Nugent, 2008). These symptomatic changes were related to income level, employment status, and negative expectations of the disability claim process. The increase in psychiatric symptoms during the change process was attributed to the stress of the claims process itself (Spoont et al., 2008). Increased symptomatology was demonstrated in an independent setting outside of the claims process. The authors claimed there were no incentives for the subjects to overreport to an independent researcher. Therefore, the increase in symptoms was attributed to actual stressors and not manufactured to increase benefits (Spoont et al., 2008).

This mistrust by VA staff might be caused by the high number of veterans who seek PTSD treatment concurrently with filling a disability claim. A high percentage, between 69 and 94 percent, of those seeking care for PTSD are also applying for disability benefits (Frueh, Elhai, Gold, Monnier, Magruder, Keaned, & Arana, 2003). This high percentage of claimants who are concurrent-care seekers demands further examination. Only half of disability claimants seek care for PTSD, of that half, 73 percent of those seek care from the VA. These numbers suggest that even though most of the veterans being treated for PTSD at the VA are benefits seeking, they are roughly 36 percent of the total number of disability claimants. Thus, the VA is providing treatment for a small percentage of veterans who claim to be disabled by PTSD. They are serving an even smaller number of non-benefit seeking veterans with PTSD. Clearly, the VA is not effectively reaching the majority of veterans suffering from PTSD.

Conclusion

The VA has designed its modern system to serve the most disabled and impoverished clients. Access to services for working veterans who have not been classified as disabled is blocked by waiting lists and sometimes co-payments. The structure of the VA impedes a rapid response to policy changes. The Veterans' Administration continues to provide mental health services through its hospital system. This limits the accessibility and quality of mental health care. Although there have been some quality improvements in VA treatment for depression, treatment for PTSD is only in process (Rand, 2008). Only half of those receiving mental health services for PTSD received only minimally adequate care. In that half, those receiving evidence based care for PTSD represent just a small portion (Rand, 2008). The VA continues to struggle to provide quality care which is supported by research outcomes. Keeping up with the changes and increasing demands of returning soldiers is a daunting task given the size and structure of the VA. Unlike active military personnel who have a managed care system where they have many

choices of where to seek care, disabled and poor veterans can generally only rely on the VA hospitals and clinics. This bureaucratic behemoth is ill-equipped to expand and react to the ever changing needs of veterans returning from this protracted Global War on Terror.

It its most recent report, the Rand Corporation Research Brief (2008) recommended that the VA increase the amount of and access to quality mental health services. According to the Rand Brief (2008), policies should include a plan to encourage veterans to seek PTSD care. Currently, the VA is serving only a small percentage of PTSD-afflicted veterans. Veterans are reticent about receiving care for their PTSD due to negative attitudes about therapy or concerns about the consequences of seeking care. Many seek care only when their PTSD symptoms are severe enough to render them disabled. However, PTSD is associated with chronic interpersonal, legal, occupational, and health problems. Veterans with PTSD tend to be heavy service users and suffer from a wide range of co-morbid psychiatric and physical problems (Hoge et al., 2007). If the VA fails to reach out to engage those resistant to PTSD treatment, it will continue to be burdened with caring for the physical and other psychiatric needs of these veterans.

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